GSFC REQUEST FOR ADVANCED SICK LEAVE AND LEAVE WITHOUT PAY

PART I – EMPLOYEE INFORMATION (all requestors must complete this section)

EMPLOYEE/REQUESTOR NAME:	DATE:
SSN:	WORK PHONE:
TITLE/GRADE/CODE:	

PART II – REQUEST FOR ADVANCED SICK LEAVE

(complete this section ONLY if you wish to request approval of advanced sick leave)

HOURS REQUESTED:	BEGINNING DATE:	ENDING DATE:

Type of Leave / Absence	BEGINNING DATE	ENDING DATE	TOTAL HOURS
Earned Sick leave available (must be exhausted prior to using advanced sick leave)			
Advanced Sick Leave (240 max. for personal absence; 40 max. for family-related absence)			

Purpose (must attach original medical documentation or evidence of adoption):

_____ Illness/Injury/Incapacitation of requesting employee _____ Care for family member _____ Bereavement

Family and Medical Leave

If sick leave or LWOP will be used under the Family and Medical Leave Act (FMLA), please provide the following information:

I hereby invoke my entitlement to family and medical leave for:

___ **Birth/Adoption/Foster care** ____ **Serious health condition of family member** ____ **Serious health condition of self**

(Contact your supervisor or Human Resources Specialist to obtain additional information about your entitlements and responsibilities under the FMLA.)

I understand that I will be obligated to reimburse the U.S. Government for any leave indebtedness which exists at the time of my separation from the Federal service. I consent that such reimbursement may be effected by deduction from salaries due to me at that time, or be set off from my individual CSRS/FERS retirement system account.

Employee Signature: **Date:**

Recommendation: _____ Approval
_____ Disapproval

_____
Immediate Supervisor Signature **Date**

PART III – REQUEST FOR LEAVE WITHOUT PAY (LWOP)

(Complete this section ONLY if you wish to request approval of LWOP for MORE than 30 consecutive calendar days. THIS REQUEST MUST BE ROUTED THROUGH YOUR DIRECTORATE OFFICE.)

HOURS REQUESTED:	BEGINNING DATE:	ENDING DATE:

JUSTIFICATION (attach appropriate justification):

Employee Signature: **Date:**

Recommendation:
_____ Approval
_____ Disapproval

_____
Immediate Supervisor Signature **Date**

DIRECTORATE CONCURRENCE FOR LWOP:

_____
Director Of Signature **Date**

TO BE COMPLETED BY OFFICE OF HUMAN RESOURCES ONLY

CONCURRENCE: This request _____ is _____ is not consistent with all requirements & considerations for approval as outlined in NPR 3600.1.

_____
HR Specialist Signature **Date**

This request is: _____APPROVED ____DISAPPROVED

_____
Office of Human Resources **Date**

Annual Leave accrual rate: 104 160 208
Annual leave balance: _____ Sick Leave Balance: _____
LWOP Balance: _____ Balances as of: _____

EOD Date: _____ Years of federal service: _____

Privacy Act Statement: Section 6311 of Title 5, U.S. Code, authorizes collection of this information. The primary use of this information is by management and your payroll office to approve and record your use of leave. Additional disclosures of the information may be: To the Department of Labor when processing a claim for compensation regarding a job-connected injury or illness; to a State unemployment compensation office regarding a claim; to Federal Life Insurance or Health Benefits carriers regarding a claim; to a Federal, State, or local law enforcement agency when your agency becomes aware of a violation or possible violation of civil or criminal law; to a Federal agency when conducting an investigation for employment or security reasons; to the Office of Personnel Management or the General Accounting Office when the information is required for evaluation of leave administration; or the General Services Administration in connection with its responsibilities for records management.
Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal Government furnish a SSN or tax ID number. This is an amendment to title 31, Section 7701. Furnishing the SSN, as well as other data, is voluntary, but failure to do so may delay or prevent action on the application. If your agency uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.

INSTRUCTIONS:

PART I – All employees must complete this section to request advanced sick leave and/or LWOP.

PART II – Employees requesting advanced sick leave must attach appropriate medical documentation to this request. Appropriate medical documentation must include the following:

1. **employee's name**
2. **reason for absence**
3. **approximate duration of absence**

NOTE:

- **For absences that may be intermittent in nature, medical documentation should reflect as such.**
- **For absences requested to care for a family member, medical documentation should include the family's members name & relation to employee.**
- **For absences related to adoption, a copy of adoption documentation is sufficient for this purpose.**

PART III – Only LWOP in excess of 30 consecutive calendar days must be requested on this form. Intermittent LWOP or LWOP under 30 days does not need to be requested on this form. Appropriate documentation should contain the following:

1. **employee's name**
2. **reason for absence**
3. **approximate duration of absence**

NOTE: For Military LWOP – a copy of military orders is considered appropriate documentation and is sufficient for this request.

PLEASE ALLOW AT LEAST 7 WORKING DAYS FOR THIS REQUEST TO BE APPROVED AND PROCESSED.